

**MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD**

2005 JOINT APPLICATION FOR HOSPITAL GROUPS

FOR GEOGRAPHIC RECLASSIFICATION

EFFECTIVE FEDERAL FISCAL YEAR 2007

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**PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION**

THIS APPLICATION MUST BE COMPLETED AND RECEIVED BY THE MGCRB BY  
**5:00 P.M. EDT, SEPTEMBER 1, 2005.** FAILURE TO COMPLY WILL RESULT IN DISMISSAL.

PRINT IN INK OR TYPE WHEN COMPLETING THIS APPLICATION

**I. GROUP INFORMATION**

1. NAME OF THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED:

\_\_\_\_\_

2. IDENTIFICATION CODE FOR THE AREA INDICATED IN NUMBER 1 (REFER TO GROUP INSTRUCTIONS):

\_\_\_\_\_

3. CONTACT FOR ALL COMMUNICATIONS REGARDING THIS APPLICATION:

NAME: \_\_\_\_\_

ORGANIZATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_ ZIP CODE \_\_\_\_\_ - \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

4. A. THE GROUP SHOULD PROVIDE, USING THE FOLLOWING FORMAT, A LISTING OF ALL IPPS HOSPITALS IN THE COUNTY AT **ATTACHMENT A**. COLUMNS A THROUGH C ARE SELF-EXPLANATORY. FOR COLUMN D., PROVIDE AN ASTERISK IF THE HOSPITAL IS ALSO FILING AN INDIVIDUAL APPLICATION WITH THE MGCRB. IN COLUMN E, THE GROUP MUST IDENTIFY ALL HOSPITALS WHICH ARE ALREADY RECLASSIFIED FOR THE WAGE INDEX IN FFY 2007 AS PART OF A 3-YEAR RECLASSIFICATION. COMPLETE COLUMN E BY INDICATING THE AREA IDENTIFICATION CODE TO WHICH THE HOSPITAL IS RECLASSIFIED IN FFY 2007. **NOTE:** THE BOARD WILL RULE ON A GROUP RECLASSIFICATION REQUEST BEFORE IT RULES ON A HOSPITAL'S INDIVIDUAL REQUEST. IF THE BOARD RECLASSIFIES A GROUP, IT WILL DISMISS ANY INDIVIDUAL RECLASSIFICATION APPLICATION FILED BY HOSPITALS IN THE GROUP.

<u>COL. A</u>	<u>COL. B</u>	<u>COL. C</u>	<u>COL. D</u>	<u>COL. E</u>
<u>HOSPITAL</u>		<u>MEDICARE PROV.</u>	<u>INDIVIDUAL</u>	<u>FFY 2007</u>
<u>NAME</u>	<u>ADDRESS</u>	<u>NUMBER</u>	<u>APPLICATION</u>	<u>RECLASS. AREA</u>

- B. IN SUPPORT OF 4.A. IMMEDIATELY ABOVE, INCLUDE AS **ATTACHMENT B** A CURRENT LETTER FROM THE APPROPRIATE CMS REGIONAL OFFICE WHICH LISTS ALL OF THE CURRENTLY LICENSED IPPS HOSPITALS IN THE COUNTY NAMED IN I.1. ABOVE.

## **II. RECLASSIFICATION REQUEST**

**NOTE: PLEASE READ THE ACCOMPANYING HOSPITAL GROUP INSTRUCTIONS FOR THE BOARD'S TREATMENT OF URBAN AND RURAL AREAS.**

5. NAME OF THE AREA (RURAL /URBAN AREA) TO WHICH THE GROUP IS REQUESTING RECLASSIFICATION  
(THE GROUP MAY BE RECLASSIFIED TO ONLY ONE AREA):  
\_\_\_\_\_
6. IDENTIFICATION CODE FOR THE AREA SHOWN IN NO.5 (REFER TO GROUP INSTRUCTIONS)  
\_\_\_\_\_
7. THE GROUP SHOULD CIRCLE THE RECLASSIFICATION CRITERIA UNDER WHICH IT IS APPLYING AND COMPLETE THE SECTIONS INDICATED:
- A. ALL HOSPITALS IN A RURAL COUNTY SEEKING REDESIGNATION TO AN URBAN AREA (42 C.F.R. 412.232). COMPLETE SECTIONS III, IV, V, THE WAGE INDEX COMPARISON AND THE AFFIDAVIT (S).
- B. ALL HOSPITALS IN AN URBAN COUNTY SEEKING REDESIGNATION TO ANOTHER URBAN AREA (42 C.F.R. 412.234). COMPLETE SECTIONS III, IV, VI, THE WAGE INDEX COMPARISON AND THE AFFIDAVIT (S).

## **III. GENERAL INFORMATION**

8. ARE ALL IPPS HOSPITALS IN THE COUNTY LISTED IN NO. 4 MEMBERS OF THE GROUP?  
YES \_\_\_\_\_ NO \_\_\_\_\_
9. HAVE THE HOSPITALS IN THE GROUP ALSO REQUESTED RECLASSIFICATION AS A PART OF A STATEWIDE WAGE INDEX APPLICATION FOR FFY 2007?  
YES \_\_\_\_\_ NO \_\_\_\_\_
10. IF THE GROUP APPLYING FOR RECLASSIFICATION IS AN URBAN GROUP:
- A. IS ANY IPPS HOSPITAL IN THE COUNTY CURRENTLY RECLASSIFIED BY THE CMS REGIONAL OFFICE UNDER 42 CFR § 412.103 AS BEING IN A RURAL AREA?  
YES \_\_\_\_\_ NO \_\_\_\_\_
- B. DOES ANY IPPS HOSPITAL IN THE COUNTY HAVE A PENDING APPLICATION WITH THE CMS REGIONAL OFFICE TO BE TREATED AS BEING IN A RURAL AREA UNDER 42 CFR § 412.103?  
YES \_\_\_\_\_ NO \_\_\_\_\_

IF "YES" TO EITHER 10.A. OR 10.B., PROVIDE A LIST OF THE HOSPITALS AT **ATTACHMENT C**. INDICATE IN THE LIST WHICH HOSPITAL(S), IF ANY, ARE CURRENTLY RECLASSIFIED AS BEING IN A RURAL AREA ALONG WITH THE EFFECTIVE DATE OF THE RECLASSIFICATION AND WHICH HOSPITAL(S), IF ANY, HAVE A PENDING APPLICATION WITH THE CMS REGIONAL OFFICE FOR RECLASSIFICATION UNDER THIS SECTION? (REFER TO THE INSTRUCTIONS FOR FURTHER INFORMATION.)

11. IS THE GROUP REQUESTING AN ORAL HEARING?

YES \_\_\_\_\_ NO \_\_\_\_\_

IF "YES" ATTACH RATIONALE UNDER **ATTACHMENT D**.

12. PRIOR YEAR GROUP CASE NUMBER (S):

04G \_\_\_\_\_ 05G \_\_\_\_\_ 06G \_\_\_\_\_

**IV. ADJACENCY (ALL GROUPS)**

13. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED ADJACENT (CONTIGUOUS) TO THE AREA TO WHICH THE GROUP SEEKS REDESIGNATION?

YES \_\_\_\_\_ NO \_\_\_\_\_

(ATTACH MAP UNDER **ATTACHMENT E**.)

**V. METROPOLITAN CHARACTER (RURAL GROUP ONLY)**

14. DOES THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED MEET THE STANDARDS FOR REDESIGNATION TO AN URBAN AREA AS AN "OUTLYING COUNTY"?

YES \_\_\_\_\_ NO \_\_\_\_\_

(ATTACH THE SUPPORTING U.S. CENSUS BUREAU DATA UNDER **ATTACHMENT F**.)

**VI. CSA CRITERIA (URBAN GROUP ONLY)**

15. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED A PART OF THE COMBINED STATISTICAL AREA (CSA) THAT INCLUDES THE URBAN AREA TO WHICH THE GROUP SEEKS REDESIGNATION?

YES \_\_\_\_\_ NO \_\_\_\_\_

(ATTACH OFFICIAL U.S. CENSUS BUREAU CSA LISTING UNDER **ATTACHMENT G**.)

**WAGE CRITERIA - 85 PERCENT COMPARISON (RURAL AND URBAN GROUPS)**

ATTACH THE GROUP'S AGGREGATE HOURLY WAGE COMPUTATIONS USING 3-YEAR AVERAGES OF WAGES AND HOURS FOR THE 85 PERCENT COMPARISON UNDER **ATTACHMENT H**. TAB 1 OF THE GROUP APPLICATION INSTRUCTIONS PROVIDES AN EXAMPLE OF THIS COMPARISON.

**AFFIDAVIT**

COUNTY OR PARISH OF \_\_\_\_\_

STATE OF \_\_\_\_\_

I, \_\_\_\_\_ (TYPE OR PRINT NAME), BEING DULY SWORN, DEPOSE  
AND SAY AS FOLLOWS:

- (1) I CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING APPLICATION FOR GEOGRAPHIC RECLASSIFICATION AND ALL OF THE SUPPORTING INFORMATION AND DATA INCLUDED IN THE SUBMITTAL BY \_\_\_\_\_  
\_\_\_\_\_  
(HOSPITAL NAME AND MEDICARE PROVIDER NUMBER) THAT IS DUE TO THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD NO LATER THAN SEPTEMBER 1, 2005. I HEREBY DECLARE UNDER PENALTY OF PERJURY (28 U.S.C. SECTION 1746) THAT THE FOREGOING IS TRUE AND CORRECT.
- (2) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE GROUNDS FOR DENIAL OF THE HOSPITAL'S APPLICATION.
- (3) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE CAUSE FOR LEGAL ACTION AGAINST THE APPLICANT HOSPITAL AND ITS OFFICIALS.
- (4) I CERTIFY THAT I AM AN OFFICER OF THE HOSPITAL NAMED IN (1) ABOVE OR A CORPORATE OFFICER OF THE HOSPITAL'S PARENT CORPORATION WITH AUTHORITY TO SIGN THE APPLICATION FOR GEOGRAPHIC RECLASSIFICATION ON BEHALF OF THE HOSPITAL.

SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

SUBSCRIBED AND SWORN BEFORE ME  
THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 2005  
(DAY) (MONTH)

\_\_\_\_\_  
(SIGNATURE OF NOTARY)

NOTARY PUBLIC  
MY COMMISSION EXPIRES: \_\_\_\_\_